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GOVERNOR

STATE OF MICHIGAN
OFFICE OF FINANCIAL AND INSURANCE SERVICES
DEPARTMENT OF LABOR & ECONOMIC GROWTH
DAVID C. HOLLISTER, DIRECTOR

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BILL ANALYSIS

BILL NUMBER: **Senate Bill 88 (Committee Substitute)**

TOPIC: HMO Copayments and Coinsurance

SPONSOR: Senator Hardiman

CO-SPONSORS: Senators Switalski, Kuipers, Allen, Jelinek, Goschka, Cropsey, Birkholz, and Sikkema

COMMITTEE: Health Policy

Analysis Done: October 26, 2005

POSITION

The Office of Financial and Insurance Services (OFIS) is neutral on this legislation.

PROBLEM/BACKGROUND

Michigan law requires health maintenance organizations (HMOs) to provide a comprehensive set of required health benefits, defined in the laws as basic health services. HMOs were developed to cover the services necessary to maintain members' health and manage chronic illnesses in the most comprehensive yet cost effective manner possible. This basic coverage is more expansive than other insurers are required to provide, and HMOs argue that in order for them to remain competitive and provide more options for health care purchasers, additional plan flexibility is required.

Under current law, HMOs are allowed to offer contracts—subject to OFIS review and approval--with unlimited deductibles and "nominal" co-pays for basic health care services of up to 50% of the HMO's reimbursement to an affiliated provider.

HMOs have stated that they need more flexibility in their statute in order to offer the types of plans that employers want to purchase.

DESCRIPTION OF BILL

Senate Bill 88 creates a distinction between "copayment," which is stated as a dollar amount in relation to the reimbursement rate, and "coinsurance," which is stated as a percentage of that reimbursement rate. The bill removes the requirement that co-payments that HMOs include in their contracts be "nominal" but makes clear that the Commissioner has the authority to regulate and establish reasonable co-payment and coinsurance limits, including out-of-pocket maximums.

The bill requires the Commissioner to determine whether the increased copayment/coinsurance amounts have increased the number of employers who have contracted for HMO services and whether these levels have increased the number of enrollees receiving HMO services. The Commissioner is required to hold a public hearing, to seek input from appropriate independent sources, and is required to issue a report to the Governor, the Secretary of the Senate, the Clerk of the House of Representatives, and all members of the Senate and House of Representatives standing committees on health and insurance issues by May 15, 2008 and then annually thereafter. If the results of the May report are disputed or the Commissioner determines that circumstances have changed, then the Commissioner must issue a supplemental report by December 15 of the same year.

The bill would allow an HMO to offer a healthy lifestyle program for its enrollees that enhances health or reduces risk of disease. The HMO can offer an enrollee goods, vouchers, copayment discounts, or equipment to promote the lifestyle program.

Finally, the section of the Insurance Code (MCL 500.3571) that allows HMOs to participate in certain governmental programs is being amended to explicitly state that an HMO that participates in certain federal or state programs are required to meet the solvency and financial requirements of the Insurance Code (unless that HMO is in receivership or under supervision by the Commissioner), but are not required to offer benefits or services that exceed the requirements of the state or federal program and exempts state employee or federal employee health programs.

SUMMARY OF ARGUMENTS

Pro

HMOs have always been allowed to impose nominal copayments for basic health services of up to 50% of the HMO's reimbursement to a provider for providing the service. In addition, recent changes in the law regulating HMOs allow them to offer contracts with no limitations on deductibles. Proponents of this legislation argue that greater flexibility in contract design is needed to meet employer demands. They also argue that the term "nominal" is vague and too restrictive. They believe that both copayment and deductible levels should be the choice of the purchaser and HMOs should be able to offer those choices. Proponents argue that the changes incorporated in this legislation, such as removal of the requirement that copayments be nominal, are designed to grant that flexibility in benefit design.

Individual purchasers of HMO products may find products with higher deductibles and copayments to be more affordable and choose this type of coverage over the risk of carrying no coverage at all.

Con

HMO enrollees may see larger out of pocket expenses as employers seek to pass on a larger share of the cost of the health plan to employees. HMO enrollees facing higher out of pocket costs may avoid seeking basic health services, which may result in health care costs increasing in the future.

FISCAL/ECONOMIC IMPACT

OFIS has identified the following revenue or budgetary implications in the bill as follows:

(a) To the Office of Financial and Insurance Services:

Budgetary: Some additional staff time will be required to conduct the public hearings and to prepare the report required by this legislation.
Revenue:
Comments:

(b) To the Department of Labor and Economic Growth: None known.

Budgetary:
Revenue:
Comments:

(c) To the State of Michigan: None known.

Budgetary:
Revenue:
Comments:

(d) To Local Governments within this State: None known.

Comments:

OTHER STATE DEPARTMENTS

None known.

ANY OTHER PERTINENT INFORMATION

None

ADMINISTRATIVE RULES IMPACT

OFIS does have general rulemaking authority under the Insurance Code of 1956, 1956 PA 218.

Linda A. Watters

Linda A. Watters
Commissioner

10-26-05
Date